

PREVENTION: PROBLEMS IN DECISION- MAKING AND IMPLEMENTATION IN MENTAL HEALTH AND MENTAL RETARDATION SERVICES*

JUNE J. CHRISTMAS, M.D.

Commissioner, Department of Mental Health and Mental Retardation Services
The City of New York
New York, N. Y.

IN considering the possible prevention of mental illness and mental retardation, it might be well to keep in mind certain questions of the type that underlie the investigative process generally: What is prevention? What are its goals and objectives? What strategies and models are appropriate to accomplish these objectives? Who should practice prevention, in what manner, with whom, and by what method? What are the results of these interventions? Are they effective? What are their costs in fiscal and human terms?

Besides serving as a background to the more explicit discussion that will take place today, these questions raise certain issues for program planners, those responsible for social policy, and those charged with the allocation of resources. Before progress can be made in resolving these issues, we must examine these basic questions, whose complexity may be masked by the simplistic way in which they have been posed.

Basic to any understanding of strategies of prevention is the awareness that this is an exceptionally undisciplined area of concern. The somewhat global concept of primary prevention has received renewed attention from those in the mental health field. At the same time, concerned laymen and interested communities increasingly are expressing demands for preventive approaches. Yet it is questionable whether the professionals and citizens are seeking the same goals. This uncertainty can be interpreted as a need for greater clarity in the definition of terms.

Gerald Caplan has defined primary prevention in mental health as "lowering the rate of new cases of mental disorder in a population over

*Presented in a panel, *Strategies for Prevention: Mental Illness and Mental Retardation*, as part of the 1974 Annual Health Conference of the New York Academy of Medicine, *Prevention and Health Maintenance Revisited*, April 25 and 26, 1974.

a certain period of time by counteracting harmful forces before they have a chance to produce illnesses.”* This definition is an attempt to use the public health concepts of primary, secondary, and tertiary prevention in the field of mental health and to broaden the idea of causation from its more narrow definition in physical illness. In this view, primary prevention relates to changing the socioeconomic environment and modifying or altering those negative external forces that influence human growth and development.

Under this rubric such varied approaches have been included as education, consultation, counseling, and information in the traditional mental health arena and, in a more radical vein, social and economic efforts such as legislation to change housing conditions, food programs, welfare reform, pensions for workers, and the like. To broaden Caplan's definition to include social and psychological interventions which are designed to make the physical and social environment more stimulating to growth may involve recognition of the complex and not fully understood relation between the development of personality and social forces. This recognition, however, makes the infrequently addressed problem of evaluation (of which mention will be made later) even more difficult.

The stresses of a changing society—of living under conditions of poverty, discrimination, mounting anomie, and alienation—are such that concerns of mental health cannot be separated sharply from social issues or from the socioenvironmental aspects of health care, education, and employment. Yet this approach poses a dilemma. To attempt to address adequately the social and economic factors that interfere with mental health may channel the limited amount of skills and resources available to larger problems that have, until now, seemed insoluble. On the other hand, to provide services without recognition of the complicating deleterious effects of social deprivation may be to ignore the causes of the very symptoms with which we are attempting to deal. Certainly, the following aims are ripe for mental health concern: to understand the effects of the feelings and actuality of powerlessness on the development of self-esteem and the ability to cope; to gain further knowledge of the effects of material deprivation on growth, the development of personality, and the formation of identity; to unravel the conflicting evidence concerning the influence of factors such as race and poverty on

*Quoted from Wagenfeld, M. O.: The primary prevention of mental illness. A sociological perspective. *J. Health Soc. Behav.* 13:195, 1972.

the incidence of mental illness; to apply the knowledge of developmental tasks and stresses, learning, and coping skills to interpersonal relations, social competence, and human relations—and to do all this in a manner that contributes to the prevention of mental illness and the fostering of mental health.

This view requires, however, a new conception of concern for mental health, service systems based on this broadened vista, and a high priority given to prevention and rehabilitation. Such an orientation assumes that plans will be made for the services needed by an entire population group, not only those individuals who are identified as patients or clients by themselves or others. In regard to mental health, attention is given through preventive efforts not only to current needs, but to potential needs. In this formulation, planned social, educational, and psychological interventions recognize and utilize the support systems and social networks of the environment.

Hand in hand with this approach goes the planning and provision of services on a community basis—not only to ensure that they are both available and accessible, but in order to make them responsive to locally identified needs and expressed demands. This requires a structure by which these demands may not only be expressed, but by which they can also affect the ultimate provision of funds, the development of policy, and the operation of programs. Ideally, such programs should draw upon the culture and life-styles of the community and relate to its people—not only as consumers, recipients of services, and staff members but as joint planners with the agencies which are providing the services, those with supervisory and planning authority, and the makers of public policy who are responsible for setting citywide and statewide priorities.

In keeping with an emphasis on decentralization, we must acknowledge that as localities and people vary so their needs also must vary. It thus becomes necessary to describe the conditions and assess the status of the specific population under consideration and to use these data for rational planning. The epidemiological approach and the collection of information can reveal patterns of utilization, gaps, and, occasionally, duplications in service. Demographic data and the development of social indicators may suggest possible correlations between socioeconomic factors and mental disorder. They also may indicate possible influences encouraging or hindering entrance into the health-care systems. This

is only one area which is ripe for exploration and consideration of program planning. Such utilization and psychological information will have to be sought increasingly if prevention is to be carried out more extensively.

As one example, there seems to be a consistent correlation between psychopathology and large discrepancies between achievement and aspiration. Does susceptibility to mental disorder increase with anticipation of or actual failure to reach desired goals, with frustration, and with the unrelieved and prolonged high levels of stress involved in reaching such goals? These possibilities have implications for a necessary new thrust toward prevention, particularly with the natural social networks of the home, neighborhood, school, and extended family.

Priority should be given to populations at high risk even when they are not those most easily helped, most ready to seek assistance, or most articulate in expressing their needs in the language of mental health. Yet knowledgeable as are those in the mental health fields concerning the general principles of child development and knowledgeable as they can become concerning strengths and coping mechanisms, they must place far greater emphasis on the prevention of mental disability in those large segments of the population which previously have been neglected: those facing old age and nonproductivity in a society oriented towards youth and action, the addicted and drug-dependent who are seeking escape from stress, children and youths who are going through crises of daily living and periods of adjustment of stress, struggling with learning and experiencing adaptational difficulties and their families; families who might care for the retarded and the developmentally disabled (after plans are made for the higher-priority mentally ill); ethnic minorities with their own culture impinging on the wider society; racial minorities coping with discrimination and prejudice; and those who are at risk of becoming chronically mentally ill and socially deviant.

In this social context, there are many difficulties in the development of preventive approaches directed toward that 90% of the population that does not presently have mental disorders. Problems arise concerning the allocation of resources, the definition of positive mental health as opposed to social control and imposed values, the choice of objectives—to prevent mental illness or to develop mental health—and the time and place for the application of preventive approaches. These require much further exploration than will be given here.

How can we best deploy our scarce resources? If the core of the concept is the bringing of attention to and deployment of energies toward normal people, it is obvious that virtually the entire population is eligible for such efforts. However, this goal of services for all may not be realizable nor realistic. Certainly, high risk populations or priority groups might be selected for those approaches which, if provided intensively, would result in the prevention of illness. This is a route to follow if the decision is made to concentrate on such high-risk target groups as ghetto children, the elderly, and poor children. The other alternative is to develop less intensive approaches and make them available to the population at large. Diluting our efforts to include 90% of the population under the rubric of prevention may not be productive. These are the decisions that must be made.

In place of ill-defined concepts which are hard to implement and even more difficult to measure, one approach might be to examine those families and individuals who are coping with varying degrees of adequacy and are not yet dependent on the system of mental health care. However, this approach might itself discover new cases of illness and thus generate new demands. Studies of the welfare population using the New York City Department of Social Service have shown large numbers of previously undiagnosed and untreated people with chronic mental illness. As in longitudinal studies of groups such as those followed in the Midtown Study, specific populations might be evaluated in terms of their ability to function in critical areas. The survival abilities of those members of minority groups who did not become mentally ill or flee into social pathology and the varied coping skills which carry people through the many small crises of daily living deserve attention so that we might better formulate techniques of prevention.

Criteria for evaluation of the effectiveness of preventive services are hard to come by; outcome and productivity are difficult to measure. Proof is lacking that alterations in the balance and character of physical, cultural, and socioeconomic forces in the environment can reduce mental illness. We have assumed the opposite despite the empirical evidence of a relation between mental health and the environment.

It might be productive to think in terms of both long-term and short-term time goals. To date, prevention of mental illness has been based—as has treatment—on the medical model which proved effective in the control of epidemics and physical illnesses. There are limitations to

borrowing models from medicine, since at present the causes and cures for mental illness are not as well understood as those for physical disorders. When an intervention does work it is difficult to ascertain whether the intervention itself, extraneous factors, those intrinsic to the individual in his emotional and physical state, or a combination of these plus the process of time itself led to the outcome.

In designing services, we also face the requirement that programs must be based on specific goals and have ascertainable results. Prevention programs have a low priority in governmental funding because there are no means of evaluating the few existing programs—for example, the programs to prevent learning disability within primary schools in New York City—that can prove their effectiveness to the legislators who dispense funds. There is no discipline of program design in which evaluation is incorporated in an effort to come up with hard data at the end of a designated period of program operation. Certainly the effectiveness of primary prevention of the major mental illnesses has not been tested but to do so might entail limiting mental health services provided by those well-trained professionals who are needed for the treatment of acute and chronic illnesses. Since we know that an attack on social and economic problems as they affect individual growth and development might also be made as a concomitant of prevention, would it not be wiser to approach prevention through an assault on the conditions which interfere with the development of individual potential?

Finally, in any preventive work that attempts to use the approach of consultation and education—whether through agencies, families, teachers, or caretakers—we must be mindful of the value judgments which are involved. For example, in the current child-care 'movement' decisions have been made as to the value of day-care and educational programs which prepare children for school and the relative value of these as opposed to social and economic approaches which would provide greater income for the family and greater opportunity for them to enter the economic mainstream.

Similarly, we have yet to learn whether crisis intervention by mental health services as a preventive approach to helping a particular group of people through an immediate and short-term struggle has any long-term effect on mental health.

The educational approach provided by practitioners of mental health services to the public at large through such efforts as public education

do provide the transmission of information. We have yet to learn what happens to the individuals who receive this information: how it is translated, if at all, into their everyday lives.

It may be better to attempt directly to improve those conditions which we believe interfere with individual functioning at the same time as we attempt to develop new preventive approaches. For example, consultation as applied within the school system often may be treatment rather than prevention—even, perhaps, treatment given too late. However, consultation supplied to an agency or a school may have little effect because resources in the next stages of help have not been developed. This is not to say that mental health professionals should cease providing consultation or working with community organizations, the lay public, educators, and caretakers. All this should be done in addition to their direct treatment and rehabilitative roles. But this requires training for what is a relatively new area of concern and an orientation in which they are peers with educators, legislators, community leaders, and others. We must deepen our involvement in these areas so that we can provide leadership to bring the prevention of mental disability to the fore. Perhaps psychiatrists have knowledge of the function of individuals and groups which can be applied to the solution of social problems along with information provided by other behavioral scientists. Whether this will bring about short-term results or long-term effects or interfere with the development of possible pathology remains to be seen.

To begin an assault on this complex problem it will be necessary to define those services that are in existence, to examine the methodology which each follows, and to make a disciplined determination of the goals for each type of service. Evaluation must be built in to the goals, objectives, and methods of each program to judge its outcome and effectiveness. Revision based upon whatever immediate and longer-term feedback can be gained, the generation of additional funding for new and improved programs, and the evaluation of intervention models must be part of the cycle.